STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	7823 OLD HIGHWAY # 60 SELLERSBURG, IN47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 15, 16, 17, 18, 19, 2011 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Survey team: Avona Connell, RN TC Donna Groan, RN (August 15, 16, 17, 2011) Dorothy Navetta, RN Gloria Reisert, MSW Census bed type: SNF: 18 SNF/NF: 80 Total: 98 Census payor type: Medicare: 40 Medicaid: 46 Other: 12 Total: 98 Sample: 20 Supplemental sample: 07 These deficiencies reflect state findings	F0000	This Plan of Correction is the facilities credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	cited in accordance with 410 IAC 16.2. Quality review completed 8/25/11 by Jennie Bartelt, RN.			
F0204 SS=D	A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Based on record review and interview, the facility failed to provide sufficient preparation and support to a resident who had concerns about returning home prior to being discharged. This deficient practice affected 1 of 2 residents reviewed for discharge planning in a supplemental sample of 7 residents. (Resident #103) Finding includes: During a confidential interview on 8/17/2011, a concern was voiced that Resident #103 remained upset at having to be discharged on 6/22/2011 and wanted to stay awhile longer, but was told he could not as the insurance company felt he had completed his therapy back to prior level of functioning.	F0204	F 204 483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRGIt is the policy of this facility to provide sufficient preparation and orientation to residents to ensure safe and and orderly transfer or discharge from the facility.1. Resident #103 no longer resides at the facility. Resident # 103 was discharged home on 06/22/2011 with Amedysis Home Health Agency, Gould's home equipment supplied a hospital bed, sliding board, gel overlay to wheelchair and bed and tub transfer bench with commode opening. Nursing provided medication education and instuctions.2. All residents discharging from facility have the potential to be affected. All residents with anticipation of	09/12/2011

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	Review of the clinical record for Resident #103 on 8/18/2011 at 1:35 p.m., indicated the resident was admitted to the facility on 4/8/2011 and discharged home on 6/22/2011. Diagnoses included, but were not limited to, status post acute respiratory failure, quadriplegic, anxiety, and depressive disorder. A 4/18/2011 "Discharge Planning" care plan listed among the approaches: "Home evaluation/recommendations (as need may indicate) at least one week prior to planned discharge; Care conference to be held prior to discharge to discuss final plans, arrangements; review available community resources with resident/family..." During an interview with Social Worker #1 on 8/18/2011 at 3:00 p.m., and with Case Manager #1 at 3:15 p.m., they indicated an initial care conference was held with the interdisciplinary team and rehab to discuss discharge plans and then again at subsequent care plan meetings, but Resident #103 only had one meeting during his stay. Documentation of these meetings indicated the discharge plan was deferred each time. The interdisciplinary charting indicated a care plan meeting was held on 4/26/2011		discharge from the facility will have a Discharge Worksheet completed by the Case Manager or Social Services employee during a meeting with the resident/family prior to discharge.3. Social Services employees and Case Management Coordinators will be in-serviced on PRO 61001-04 Discharge Plan (see attachment A), PRO 61005-01 Discharge Plan of Care (see attachment B), Discharge Worksheet FRM 65101-01 (see attachment C) by the District Director of Case Management/District Director of Clinical Operations including necessary documentation. 4. The DNS/Designee will perform a weekly audit of all planned and unplanned discharges to the community to ensure discharge planning is initiated, documented and planned per plan of care and revised as needed to meet resident's individualized needs for discharge (see attachment D). The findings of the audits will be discussed at the IDT meeting and reviewed in monthly PI meeting. After 3 months of 100% compliance is maintained, the PI commitee will determine if further monitoring is necessary.5. Social Services will be responsible to ensure this standard has been met.	

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	between Social Worker #1 and Occupational Therapist #1, but the resident and family were not present. The note also indicated the discharge plans were deferred at this time. A 6/21/2011 nursing note indicated the following: "0800 [8:00 a.m.]...pt [patient] cont [continues] to be concerned about going home - doesn't feel like he is ready - reassurance given..." During an interview with Social Worker #1 on 8/18/2011 at 3:00 p.m., she indicated she had had several conversations with the resident about his anxiety in returning to home but never did document them. She indicated when the resident was first admitted, he was apprehensive about everything he would have to do, but then became very comfortable and secure here. She also indicated she and the resident had had several discussions of his options versus going home even when he was not apprehensive, but she did not document these conversations. During an interview with Case Manager #1 on 8/18/2011 at 3:15 p.m., she indicated she had made a referral to one of the local home health agencies when they came into the building one day for when the resident went home. The home health			

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agency listed in the Case Manager's notes dated 6/22/2011 was different from the one listed on his discharge instructions. She indicated she worked a lot with the insurance company to get his approvals to stay and did not document every thing she did and care plans as she did not have time due to a heavy case load.

The Case Manager indicated she would chart only the important things and was told the documentation was to only be in the soft chart, not the clinical record. She indicated there was no discharge meeting with the resident or family prior to his going home because the insurance company was quick to deny him this last time. Review of the "soft charting" completed by Case Manager #1 contained documentation of the exchange of information between the facility regarding the resident's care needs and the insurance company in order to qualify for continual stay.

On 8/19/2011 at 9:10 a.m., the Administrator in Training [AIT] presented a copy of the signed Job Description for Case Manager #1 dated 7/6/2010. Review of this Job Description at this time indicated one of her "Essential Functions" included "Discharge Planning".

The AIT also presented a copy of Job

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	Description for "Case Management Coordinator". One of the "Essential Functions" also included "...Provides oversight of Medicare and Managed Care residents and coordinates rehabilitation, optimal recovery and discharge planning..." During an interview with the Rehabilitation Manager on 8/19/2011 at 8:20 a.m., she indicated a home evaluation was never performed because of the timing of his insurance company discharging him, he said he was getting a new apartment and did not want to do one in his old place, his mom was out of town and he wanted to wait for her, and he seemed embarrassed by his living area. 3.1-12(a)(21)			
F0247 SS=D	A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure a resident received notice prior to a room change due to a facility construction project. The facility also failed to ensure the resident was provided an explanation and support to	F0247	F 247 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGEIt is the policy of this facility to notify residents before the resident's room or roommate in the facility is changed.1. Resident #68 has	09/12/2011

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	deal with the temporary move to a new room. This deficient practice affected 1 of 1 resident reviewed related to room changes in a supplemental sample of 7. (Resident #68) Findings include: On 8/17/2011 at 9:50 a.m., clinical record review for Resident #68 indicated diagnoses included, but were not limited to, cerebral vascular accident (CVA), hypertension, seizure disorder, coronary artery disease, and history of brain aneurysm. The Social Worker Progress Notes, dated 6/16/2011, indicated Resident #68 was brought to the lobby and requested to talk to the Social Worker. The notes indicated Resident # 68 was agitated, would not go into the temporary room, and Social Worker (SW) # 1 "attempted to reason with res. [resident] Res. was steadfast that she would not be staying here...." SW # 1 advised nurse and Certified Nurses Aide (CNA) "that if res. attempts to exit the bldg. [building], wanderguard to be initiated immediately." Review of the facility's Notification of Room Change Advance Notification, dated 6/16/2011 at 8:30 a.m., indicated Social Services obtained a telephone		been discharged from the facility. Prior to room transfer, notification and permission were received by resident #68's daughter and son. This resident also returned to prior room after a new floor had been laid.2. All residents have the potential to be affected, in the event of a necessary room change the resident will be informed and an explanation and support provided and documented in the chart.3. Social Services staff and all department heads will be in-serviced on POL 603-12 Change in Resident Room or Roommate (see attachment E) and PRO 61000-03 Room to Room Transfer (see attachment F) by the DNS/designee.4. All potential room changes will be reviewed during IDT morning meeting. Social Services will ensure that the resident and family receive notice prior to the resident's room change including an explanation and support and documented in resident's chart. A weekly audit of all room or roommate changes will be completed for 3 months by the Executive Director/Designee (see attachment G) and the findings of these audits will be reviewed in monthly PI or until compliance has been met.5. The social services Director will be responsible to ensure compliance with this standard.	

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verbal consent from the resident's daughter, and at 10:00 a.m., from the son who has power of attorney (POA), indicating Resident #68 could be moved into a temporary room because of construction to the floor.

Review of the facility's Notification of Room Change Advance Notification, dated 6/20/2011, indicated Resident # 68 was moved back to her former room. A verbal consent was given by the POA.

On 8/17/2011 at 10:50 a.m., in an interview with Social Worker (SW) # 1 she indicated she thought she documented more and "can't explain why documentation isn't there." SW #1 indicated Resident #68 is alert and oriented to person, place and time. Documentation was lacking any follow up was done to ensure the psychosocial well being of Resident # 68.

On 8/16/2011 at 1:30 p.m., in an interview with Resident #68 during the group meeting she indicated the facility changed her room, even though she did not want to move. She indicated she was still upset about the move, even though she had been moved back into her previous room.

Activity Director #1 indicated all

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	residents present at group interview were alert and oriented to person, place and time. On 8/17/2011 at 12:10 p.m., review of policy and procedure on Room-to Room Transfer under compliance guidelines indicated, "1. Center discusses transfer with resident, family, and/or responsible party in advance to explain rationale. 2. Residents are offered an opportunity to tour the the room prior to a room move. 3. Residents are introduced to the new roommate prior to a room move." Documentation was lacking a tour was done prior to the move. On 8/17/2011 at 12:10 p.m., in an interview with the Administrator, he indicated the move was necessary due to the fact the facility was doing construction on all the floors down the 300 hall. 3.1-3(v)(2)			

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F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Navetta, Dorothy Based on record review and interview, the facility failed to ensure the resident received social services for emotional support and assistance in discharge planning in preparation to return home (Resident #103), and during a temporary relocation to a different room during a construction project at the facility (Resident #68). This deficient practice affected 2 of 2 residents reviewed related to social services in a supplemental sample of 7. (Residents # 68 and #103) Findings include: 1. The clinical record for Resident #68 was reviewed on 8/17/2011 at 9:50 a.m. The record indicated the resident's diagnoses included, but were not limited to: cerebral vascular accident, (CVA) hypertension, seizure disorder, coronary artery disease, and history of brain aneurysm. The social worker Progress Notes dated 6/16/2011 indicated that Resident # 68 was brought to lobby and requested to talk to social worker. Progress notes indicated that Resident # 68 was agitated and would not go into temporary room and that	F0250	F 250 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICESIt is the policy of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.1. Resident #103 and resident #68 have been discharged from the facility. Residents were provided emotional support during room transfers and discharge processes.2. All residents with the potential to discharge home and all residents with the potential for a room change have the potential to be affected. All residents with anticipation of discharge from the facility will have a Discharge Worksheet completed by the Case Manager or Social Services employee during a meeting with the resident/family prior to discharge. In the event of a necessary room change the resident will be informed and an explanation and support provided and documented in the chart prior to the room change and support after the room change.3. Social Services staff will be in-serviced on documentation for emotional support provided to residents. 4. All residents with discharge plans and all residents	09/12/2011

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	social worker (SW) # 1 "attempted to reason with res. Res. was steadfast that she would not be staying here...". SW # 1 advised nurse and Certified Nurses Aide (CNA) "that if res. attempts to exit the bldg. [building], wanderguard to be initiated immediately." Review of the facility's Notification of Room Change Advance Notification, dated 6/16/2011 at 8:30 a.m., indicated social services obtained a telephone verbal consent from the resident's daughter, and at 10:00 a.m. from the son, who has power of attorney (POA), indicating that Resident # 68 could be moved into a temporary room because of construction to floor. Review of the facility's Notification of Room Change Advance Notification, dated 6/20/2011, indicated that Resident # 68 was moved back to her former room. A verbal consent was given by the POA. On 8/17/2011 at 10:50 a.m., in an interview with Social Worker (SW) # 1 she indicated that she thought she documented more and "can't explain why documentation isn't there". SW #1 indicated that Resident #68 is alert and oriented to person, place and time. Documentation was lacking that any follow up was done to ensure the		with a room change or roommate change will have documentation in resident's chart regarding the need for emotional support and audited with the weekly audit for Discharge Plans and Room Changes (see attachment D & G) for 3 months by the DNS/Designee and the findings of these audits will be reviewed in monthly PI or until compliance has been met.5. The Social Service Director will be responsible to ensure compliance with this standard.	

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	psychosocial well being of Resident # 68. On 8/16/2011 at 1:30 p.m., in an interview with Resident # 68 during the group meeting, she indicated that the facility changed her room, even though she did not want to move. She indicated that she was still upset about the move, even though she had been moved back into her previous room. Activity Director #1 indicated that all residents present at group interview were alert and oriented to person, place and time. On 8/17/2011 at 12:10 p.m., review of policy and procedure on Room-to Room Transfer under compliance guidelines indicated, "1. Center discusses transfer with resident, family, and/or responsible party in advance to explain rationale. 2. Residents are offered an opportunity to tour the the room prior to a room move. 3. Residents are introduced to the new roommate prior to a room move." Documentation was lacking that a tour was done prior to the move. On 8/17/2011 at 12:10 p.m. in an interview with the Administrator, he indicated that the move was necessary due to the fact the facility was doing construction on all the floors down the			

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	300 hall. 2. Review of the clinical record for Resident #103 on 8/18/2011 at 1:35 p.m., indicated the resident was admitted to the facility on 4/8/2011 and discharged home on 6/22/2011. Diagnoses included, but were not limited to, status post acute respiratory failure, quadriplegic, anxiety, and depressive disorder. Review of a 4/18/2011 care plan on "Discharge Planning" indicated the goal was "discharge anticipated to home" with an approach of "assist resident and family as needed during decision making process re: discharge plans" with Social Services as the responsible discipline. A 6/21/2011 nursing note indicated the following: "0800 [8:00 a.m.]...pt [patient] cont [continues] to be concerned about going home - doesn't feel like he is ready - reassurance given...." During an interview with Social Worker #1 on 8/18/2011 at 3:00 p.m., she indicated she had had several conversations with the resident about his anxiety in returning to home but never did document them. She indicated when the resident was first admitted, he was apprehensive about everything he would have to do, but then became very comfortable and secure here.			

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	On 8/18/2011 at 3:05 p.m., the Administrator In Training [AIT] presented a copy of the facility's current policy on "Discharge Plan of Care". Review of this policy at this time included, but was not limited to, "...Procedure: Admission:...3. Indicate the resident outcome to be accomplished before discharge on the resident's interdisciplinary plan of care. This may include, but is not limited to:...e. Resident/family anxieties or fears to be resolved...." Social Worker #1 also indicated that the resident was discussed in an initial care plan on 4/26/2011, but that the Case manager was responsible for all of the resident's discharge planning. Documentation was lacking of a care plan by Social Services which addressed the resident's fears and concerns about going home. Review of Social Worker #1's Job Description signed on 7/8/2009 included, but was not limited to the following job duties: "...Advocacy functions: works with the resident, family/significant others and other team members to outline goals of stay at admission, the plan to meet those goals and discharge as appropriate...Clinical Functions:...Documents observations and			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	7823 OLD HIGHWAY # 60 SELLERSBURG, IN47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	events in the resident's medical record as needed; assesses and documents psychosocial impact of life events, health concerns, condition changes.." 3.1-34(a)			
F0278 SS=A	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review, observation and interview the facility failed to accurately assess and document in the minimum data	F0278	F 278 It is the policy of this facility to accurately access and document in the MDS for previous falls.1. Resident #34 had	09/12/2011

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	set (MDS) for previous falls. This affected 1 of 3 residents reviewed for falls in a sample of 20 and a supplemental sample of 7. (Resident # 34) Findings include: On 8/16/2011 at 9:45 a.m., the clinical record for Resident #34 was reviewed. The resident's diagnoses included, but were not limited to: hypertension, chronic obstructive pulmonary disease, anemia, coronary heart failure and hypothyroidism. A post fall evaluation sheet dated 7/16/2011 at 8:25 a.m., indicated, "The w/c [wheelchair] moved when she grabbed ahold of it, leading to her fall." The initial MDS (Minimum Data Set) assessment, dated 8/20/2011, under Section J1800 was coded (0) indicated, "No falls occurred since admission." On 8/16/2011 at 10:30 a.m.,. in interview with the MDS Coordinator # 2, she indicated she did not see the record of a fall, dated 7/17/2011, and the MDS was "coded wrong." On 8/19/2011 at 10:00 a.m., Resident #34 was discharged to home and was observed in a wheelchair leaving the facility. 3.1-31(i)		a modification completed to the MDS and transmitted to the state on 08/16/2011.2. Any resident with a fall has the potential for an MDS with an error in coding. All incorrect coding will be corrected and transmitted to the state.3. The MDS coordinators will be in-serviced on correct coding of the MDS related to a fall. The DNS will verify weekly with the MDS coordinators the residents that had a fall that week for correct coding on the MDS and have the MDS coordinator sign off on the weekly fall log.4. The DNS/Designee will report findings to the PI commitee monthly for 3 months. If after 3 months 100% compliance is maintained, the PI commitee will determine if further monitoring is required.5. The DNS/Designee will be responsible to ensure this standard has been met.	

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure the resident was supervised to prevent the resident's falling from bed for 1 of 3 residents reviewed related to falls in a supplemental sample of 7. (Resident #102) Findings include: Resident #102's clinical record was reviewed on 08/17/11 at 11:55 a.m. The resident was admitted to the facility on 07/28/11, with diagnoses including, but not limited to: anoxic brain injury secondary to hypoglycemia (lack of oxygen to the brain due to low blood sugar), anxiety, encephelopathy (altered brain function) and hypertension (high blood pressure). Nurses notes dated 08/09/10 at 9:30 p.m., indicated the resident was found on floor on mat next to the bed at 6:00 p.m. The resident had pulled tracheotomy mask off, disconnected the trach (breathing tube) setup, and pulled out the Foley catheter	F0323	F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICESIt is the practice of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.1. Resident #102 no longer resides at the facility.2. All residents requiring supervision to reduce risk of accidents and hazards have the potential to be affected. The CNA was in-serviced and counseled on supervision to prevent accidents on 08/10/2011.3. The SDC/Designee will in-service all nursing staff, on POL 618 Accidents and Supervision to Prevent Accidents (see attachment H). The IDT will evaluate factors leading to a fall in an effort to support relevant and consistent interventions to try to prevent future occurrences. Residents will be assessed on a continuim of care to determine whether supervision is necessary and implement measures for the resident at risk for falls.4. All	09/12/2011

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	(tube into bladder). Nurses notes dated 08/10/11 at 12:15 a.m., indicated the resident was found on the floor at bedside. No injuries were noted. Nurses note 08/10/11 at 10:00 a.m., indicated the resident was still moving about in bed. The bed was then placed against wall on the right side and a full mattress was placed on the left side of the bed. The bed was put into low position and a bed alarm was in place. Nurses notes 08/10/11 at 12:00 p.m., 1:30 p.m., 2:15 p.m., and 2:30 p.m., indicated the resident was found sideways on " both mattresses" (for the low bed and the mattresses on the floor) and it took 5 staff members to reposition resident onto bed. The physician was notified at 3:00 p.m., and a request was made for an enclosure bed with full side rails. The physician's order was received, and the resident was placed in the bed on 08/10/11. The physician's order was clarified on 08/11/11 at 11:50 a.m., to read, "Enclosure bed with full side rails X 2 secondary to poor safety awareness related to anoxic brain injury to protect from accidents or injuries." Nurses notes, dated 08/11/11 at 08:15		Falls will be reviewed monthly in the PI meeting to ensure a safe resident environment that is both center focused and resident directed in approach.5. The DNS/Designee will be responsible to ensure this standard has been met.	

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a.m., indicated, "CNA (certified nursing assistant) alerted this nurse to pt. (patient) room. Pt noted to be on (L) side of bed laying on (L) side of body on the floor. BLE (both lower extremities) extended out, LUE (left upper extremity) laying bend @ elbow under pt (L) side. RUE (right upper extremity) extended out. Pt. alert & nonverbal per norm. Moves all extremities without s/s (signs/symptoms) pain/discomfort. No s/s injuries. CNA states while providing AM care, she turned to reach for item & pt fell from bed. Neuro checks WNL (within normal limits) for pt. PERL (pupils equal reactive light). Pt assisted back to bed with hoyer lift. V/S 109/62, (blood pressure) 98.6 (temperature) 92 (pulse) 21 (respirations) O2 (oxygen) at 95% BS (blood sugar) 435. NP (nurse practitioner) & unit manager notified @ this time. Enclosure bed zipped & siderail up. Staff educated on making sure siderail & enclosure around bed is in proper position before turning back to pt."

A Post Fall Evaluation dated 08/11/11 at 08:15 a.m. indicated under Description of Fall: "CNA in room providing AM care. Bed unzipped & CNA turned her back to reach for item. Pt fell out of bed @ this time."

On 08/17/11 at 3:20 p.m., the Staff

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	Development Coordinator provided the manufacturer operation manual for the enclosure bed. Page 4 indicated, "Warning: Never leave patient in bed without complete closure and locking of the unit." In interview with the Staff Development Coordinator at this time, she indicated the CNA should have asked for assist to care for the resident. Review of the resident's care plan on 08/18/11 at 10:00 a.m., indicated the following was listed on 08/08/11: Problem: Potential for falls/injury related to impaired cognition. Under approach, the following was added on 08/10/11: Enclose bed with full side rails, CNA education and while providing care have two staff. 3.1-45(a)(2)			

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F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on record review, observation and interview the facility failed to ensure the double lumen peripheral inserted central catheter (PICC) was flushed according to policy and procedure and standards of care. This affected 1 of 1 resident reviewed for a PICC line in a sample of 20. (Resident # 8) Findings include: On 8/15/2011 at 1:45 p.m., review of the clinical record for Resident #8 indicated the resident had diagnoses of, but not limited to, cerebral vascular accident (stroke) with left sided weakness, diabetes mellitus, hypertension, depressive disorder, impaired communication related to intracranial hemorrhage, coccyx wound with wound vac in place, gastronomy tube (g-tube)(feeding tube), and Methicillin Resistant Staphylococcus Aureus (MRSA) in the sputum.. Nurses notes, dated 8/3/11 at 6:00 p.m.,	F0328	F 328 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDSIt is the practice of this facility to ensure that residents receive proper treatment and care for the following special services;Injections;Parental and enteral fluids;Colostomy, ureterostomy, or ileostomy care;Tracheosotomy care;Tracheal suctioning;Respiratory care;Foot care; and Prostheses.1. No further corrective action was necessary for resident #8.2. Residents with a PICC have the potential to be affected. The SDC/Designee have completed IV Site Care and Maintenance skills check off for correct pre and post flush of a PICC.3. Licensed nurses will be inserviced on IV Site Care and Maintenance for correct pre and post flush of a PICC. The DNS/Designee will conduct random audits monthly for skills validation related to Pre and Post PICC flush (see attachment I).4. The DNS/Designee will report the	09/12/2011

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	indicated Resident # 8 had two bottles of Vancomycin (antibiotic) connected to both ports, and both were empty. The Medication Administration Record (MAR) for 8/3/11, indicated a dose of Vancomycin HCL 1500 m.g. intravenous (IV) was given at 6:00 a.m. and 2:00 p.m. A physician's order dated 8/01/2011 - 8/31/2011 indicated each PICC lumen was to be flushed with 10cc's normal saline every shift and before and after medications. On 8/15/2011 at 3:15 p.m., in interview with Registered Nurse (RN) # 1, she indicated on 8/3/11 at 6:00 p.m., she found the two bottles still connected to each port, and she took the bottles down and flushed both lumens. On 8/15/2011 at 4:20 p.m., observation of Resident # 8 indicated a PICC line was in his left arm. On 8/19/2011 at 12:20 p.m., review of the policy and procedure on "IV Site Care and Maintenance Flush Chart" included, but was not limited to, "PICC pre-use flush with 10 milliliter (ml) saline and post-use flush with 10 ml saline." 3.1-47(a)(2)		findings of the audits to the PI commitee monthly for a period of 3 months. The PI commitee will determine if further monitoring is required.5. The DNS/Designee will be responsible to ensure this standard has been met.	

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure clinical records were complete for 1 of 3 residents reviewed related to dialysis communications. This deficient practice affected 1 of 20 sampled residents whose records were reviewed. (Resident #73) Findings include:	F0514	F 514 483.75(a)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLEIt is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the state; and progress notes.1. All dialysis communication is current for resident # 73.2. All residents receiving dialysis have the potential to be affected. All residents receiving dialysis have been reviewed and	09/12/2011

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	Review of the clinical record for Resident #73 on 8/18/2011 at 9:00 a.m., indicated the resident had diagnoses which included, but were not limited to, anemia, diabetes mellitus, and congestive heart disease, and the resident attended dialysis 3 times a week. During an interview with the Medical Records clerk on 8/18/2011 at 8:50 a.m., she indicated there was a separate dialysis communication book for each resident on dialysis which contained a form the facility filled out on how the resident was upon leaving the facility, and was then completed by the dialysis center on the resident's stay each time.		communication with the dialysis center current.3. Licensed Nurses will be in-serviced on PRO 66204 Hemodialysis (see attachment J) by the SDC/Designee.The DNS/Designee will audit the dialysis communication weekly to ensure completeness (see attachment k).4. DNS/Designee will review findings in the monthly PI meeting for a period of 3 months. If after 3 months 100% compliance is maintained the PI commitee will determine if further monitoring is required.5. The DNS/ Designee will be responsible to ensure this standard has been met.	

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	Review of the dialysis communication book failed to indicate documentation of communication between the facility and the dialysis center after 6/27/2011. On 8/19/2011 at 3:00 p.m., the Director of Nursing [DON] presented Post Treatment Documentation from the dialysis center dated 7/1/2011 through 8/17/2011. During an interview at this time, the DON indicated the communication forms were sent back with the resident after each visit but must have been misplaced somewhere so she had requested copies. On 8/17/2011 at 11:40 a.m., the Administrator presented a copy of the service agreement between the facility and [name of dialysis center]. Review of this agreement at this time included, but was not limited to:...2. Written Protocol:...The Nursing Facility will provide for the interchange of information useful or necessary for the care of the resident...5. The Dialysis Center...D. Provide to the Nursing Facility information on all aspects of the management of the residents care related to the provision of dialysis services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding/hemorrhage, infection/bacteria, and care of dialysis access site and disinfection of dialysis access site...."			

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	3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3)			